NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

815 16TH STREET, N.W., WASHINGTON, DC 20006 • PHONE 202-737-5315 • FAX 202-737-1308

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Submitted electronically to:
Notice.comments@irscounsel.treas.gov

CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-52 - The excise tax on high cost employer-sponsored health coverage

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to provide comments on the above-referenced Notice issued by the Department of Treasury (Treasury) and the Internal Revenue Service (IRS). Notice 2015-52 (the "Notice") describes a number of approaches Treasury and IRS are considering with respect to certain issues under Internal Revenue Code ("Code") § 4980I (the excise tax on high cost employer-sponsored health coverage) and invites comments on these approaches and related issues. Treasury and IRS addressed other issues relating to the excise tax in Notice 2015-16[1] and have indicated that after comments on both Notices have been reviewed, proposed regulations will be issued. NCCMP has both general and specific comments relating to the issues raised in the Notice. NCCMP also looks forward to providing additional comments on issues under § 4980I as further guidance is developed.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the over 20 million active and retired American workers and their families who rely on multiemployer plans for retirement, health and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans and contributing employers in every major segment of the multiemployer plan universe, including in the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service, steel and trucking industries.

[1] The NCCMP provided comments on Notice 2015-16 by letter dated May 15, 2015, submitted via email to Notice.comment@irscounsel.treas.gov

BACKGROUND RELATING TO MULTIEMPLOYER PLANS

One of the crowning achievements of collective bargaining over the past 50 years is the creation of thousands of labor-management, multiemployer health and welfare trust funds that provide to covered workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as "Taft-Hartley funds" because they are regulated by the Labor Management Relations ("Taft-Hartley") Act of 1947, as well as by ERISA and the Code. We note, however, that some single-employer plans may operate as joint labor-management funds and therefore believe the more appropriate term is "multiemployer" plans with respect to comments contained herein.

Multiemployer plans provide health and welfare plan coverage to plan participants and their dependents pursuant to the negotiated wages, hours, and other terms and conditions of employment (including requiring contributions to be made to a multiemployer benefit trust) of a collective bargaining agreement between one or more unions and more than one employer. Even for employees who are not union members but whose work is covered as part of a certified bargaining unit, existing labor law provides that discussions of employee benefits are a mandatory subject of bargaining and therefore subject to negotiation with the union under their status as the statutory bargaining agent. The Affordable Care Act (ACA) did not repeal the Labor Management Relations Act. Relationships are established between employers and employees under the Taft-Hartley Act, and these relationships should continue to be recognized in regulations implementing the ACA.

Health and welfare trust funds cover workers in industries as diverse as agriculture, aerospace, bakery and confectionery, building and construction, trucking, transportation, retail, food production, distribution and sales, clothing, health care, textiles, service, mining, entertainment, hospitality, maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. Indeed, were it not for these plans, many millions of workers in these funds would not be eligible for coverage even under the enhanced eligibility requirements mandated for employers by the ACA. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

GENERAL COMMENTS ON NOTICE 2015-52

As we noted in our prior comments regarding Notice 2015-16, the § 4980I excise tax has already begun to impact employment-based health plans, despite the 2018 effective date. Plan sponsors are already examining whether current plan designs will trigger the excise tax and trying to anticipate what benefit designs will be consistent with avoiding the tax. The tax imposes significant new burdens on multiemployer plans, employers, and insurers, from both a planning and compliance perspective. Ultimately, however, it is plan participants who will bear the burden of the tax. Although the tax has sometimes been referred to briefly as the "Cadillac plan" tax, with the implication that only "luxury" health plans will be affected, it is now well recognized as a misnomer. The parameters of the tax are such that many fairly basic plans will be affected merely because health care costs continue to increase. The impact may also depend

on geographic area, age, and gender. Perhaps it would be more accurate to describe the tax as the "basic transportation car" or even "scooter" tax.

Although the statutory incidence of the tax is placed not on employees, the practical reality of the market place is that the cost will be passed on in one way or another to plan participants and beneficiaries. Given this reality, it is particularly important that Treasury and IRS implement the specifics of the tax in a reasonable manner, and in such a way as to avoid unnecessary burdens on all those affected.

Our prior comments included general comments in relation to the issues raised in Notice 2015-16.[2] With respect to the issues raised under Notice 2015-52, the NCCMP encourages Treasury and IRS to keep in mind the following general principles as guidance is developed under § 4980I:

- **Final guidance should reflect the particular statutory provisions for multiemployer plans and the unique structure of such plans.** Multiemployer plans are structured differently than single employer plans, so that the same administrative rules that work in the single employer context are not necessarily appropriate for multiemployer plans. The statutory provisions in § 4980I reflect these differences in several instances. For example, the statute provides that any multiemployer plan coverage is treated as coverage other than self-only coverage. While employers generally are responsible for calculating the tax and notifying coverage providers of the tax, the statute provides that it is the responsibility of the multiemployer plan sponsor in the case of multiemployer plan coverage. Unfortunately, Notice 2015-52 refers repeatedly to "employers" and the notification requirements for "employers." Final rules need to appropriately consider and reflect the multiemployer plan statutory provisions and structure so that multiemployer plan sponsors (i.e., the joint board of trustees) and contributing employers may all understand their obligations and the tax can be administered in the most efficient way possible.

- **Final rules should strive to reduce administrative burdens as much as possible, including providing flexibility in appropriate cases.** Both Notices indicate that Treasury and IRS may be concerned that providing multiple options, e.g., for determining cost, may increase administrative complexity. While in some situations it may be true that options increase complexity that is not the case with respect to the excise tax. Plans and employers will need to create new systems in order to properly plan for and calculate the excise tax, but these systems will be built to some extent on existing practices and systems, which may vary among different plans/employers. For example, given the lack of guidance under COBRA, plans and employers do not currently all calculate COBRA cost in precisely the same way. Allowing flexibility to calculate cost will help reduce

[2] Specifically, the prior comments urged that the following general principles be reflected in final guidance: (1) The details of the § 4980I calculations should fully implement the statutory provisions for multiemployer plans, as contained in § 4980I(b)(3)(B)(ii). This provision states that any coverage under a multiemployer plan is treated as coverage other than self-only coverage; (2) Plans and employers should have flexibility with respect to calculating the cost of applicable coverage; and (3) Strict consistency with COBRA rules for calculating cost should not be required.

administrative burdens and complexity with respect to § 4980I. Thus, we recommend Treasury and IRS include flexibility in the final rules as they also work toward as simple rules as possible.

SPECIFIC COMMENTS ON NOTICE 2015-52

The following comments follow the order of Notice 2015-52. Section references refer to Sections of the Notice.

SECTION III: Persons Liable For the § 4980I Excise Tax

Notice 2015-52: With respect to fully-insured plans, the Notice states that the person legally responsible for paying the tax (the "coverage provider") is the insurer. For HSAs to which the employer makes contributions, the coverage provider is the employer. For other coverage, the coverage provider is the "person that administers plan benefits". Treasury/IRS contemplate two alternative approaches to defining the "person that administers plan benefits," (a) the person with day-to-day responsibility for plan benefits (which the Notices states will often be a TPA) and (b) the person with ultimate responsibility for plan benefits. In all cases, the Notice indicates that the coverage provider will generally be an entity, rather than an individual.

NCCMP Comments:

1. **With respect to self-funded multiemployer plan coverage, NCCMP recommends that the coverage provider should be the person that has ultimate responsibility for plan benefits. With respect to multiemployer plans, this will generally result in the joint board of trustees, as the plan sponsor, being the coverage provider.**

There needs to be a clear, simple way to identify the coverage provider for self-funded plans. The calculation of the tax has many inherent complexities; one of them should not be the threshold question of who has to pay the tax. Of the two approaches outlined in the Notice, NCCMP recommends the second approach with respect to self-funded multiemployer plans, i.e., that the coverage provider is the person with ultimate responsibility for plan benefits. This approach will be simpler to administer, because the person with ultimate responsibility for plan benefits will generally be determinable by the plan documents. This approach will also reduce the potential number of coverage providers. There will often be many more coverage providers under the day-to-day approach (e.g., a separate coverage provider for prescription drug benefits, a separate coverage provider for major medical benefits, and a separate coverage provider for certain specialty benefits provided under the same plan), even though a single cost of applicable coverage would be determined with respect to the overall benefits provided. Any large plan is likely to have multiple providers in any event, such as where some benefits are self-funded and some are fully insured. The definition of coverage provider for self-funded plans should not add unnecessarily to the number of coverage providers. The more coverage providers there are, the more difficult the tax will be to administer for the IRS, plans sponsors, and coverage providers.

In the case of self-funded multiemployer plans, we believe this approach should generally result in the plan sponsor, i.e., the joint board of trustees, being the coverage provider. To avoid any

confusion, the regulations should either designate the multiemployer plan sponsor as the coverage provider or allow the board, as plan sponsor, to make it clear that the board is the coverage provider with respect to the tax.

This approach not only provides clarity, but is the simplest from an administrative perspective. As a practical matter, the only source of funds from which a multiemployer plan could pay any tax is from plan assets, over which the joint board of trustees has responsibility. Imposing liability for the tax on the multiemployer plan sponsor will also avoid issues associated with passing through of the tax by and reimbursement to third party coverage providers and will help to ensure that the cost of coverage taken into account does not include any amounts attributable to the tax.

We believe that this approach will also minimize any potential issues under title I of ERISA. The PCORI fee under Code § 4376 provides some helpful precedent here. With respect to self-funded plans, the multiemployer plan sponsor is liable for the fee, and this has worked well operationally. Further, the Department of Labor (DOL) has issued guidance providing that payment of the PCORI fee with respect to a self-funded multiemployer plan from plan assets is permissible under ERISA. We have had initial discussions with the DOL regarding title I issues under the excise tax. We encourage Treasury/IRS to also communicate with DOL regarding the mechanics of the tax so as to avoid unnecessary issues under ERISA.

If Treasury/IRS do not adopt the recommended approach, NCCMP recommends that multiemployer plans sponsors be able to designate themselves as the coverage provider for self-funded plans they sponsor. Otherwise, there may be disputes and confusion over what should be a simple question – who pays the tax?

2. With respect to fully-insured coverage, NCCMP believes that the same approach should be applied (i.e., the person with ultimate responsibility for plan benefits should be the coverage provider). This would reduce complexity.

With respect to fully-insured coverage, NCCMP believes that the simplest approach for multiemployer plans would also be that the plan sponsor is the coverage provider, rather than the insurer. We understand, however, that Treasury/IRS may view the statutory provisions as precluding the adoption of a more flexible approach.

Placing liability for the tax on the insurer in the case of fully-insured plans makes it critical that appropriate rules preventing the payment of a tax on a tax are needed. This issue is discussed further below.

SECTION V: Cost of Applicable Coverage

A & B: Taxable Period and Determination Period

Notice 2015-52: The Notice states that Treasury and IRS anticipate that the taxable period will be the calendar year for all taxpayers. In addition, Treasury and IRS anticipate that plan sponsors must determine the cost of applicable coverage provided during the taxable year sufficiently soon after the end of that taxable year to enable coverage providers to pay any

applicable tax in a reasonably timely manner. The Notice states that § 4980I(d)(2)(A) provides that the cost of applicable coverage is to be determined using rules similar to determination of the COBRA applicable premium. The Notice also asks for comments on various issues relating to the calculation, including issues associated with certain types of plans and experience-related arrangements.

NCCMP Comments:

The Board of Trustees of a multiemployer plan is accustomed to annual determinations of the cost of coverage under the plan by virtue of the annual COBRA determination process. This process has provided sufficient flexibility to allow plan sponsors to determine COBRA rates on an annual basis, for a 12-month period, and notify plan participants of the amounts when there is a qualifying event. However, the 12-month period is not necessarily a calendar year. Many multiemployer plans have a non-calendar fiscal or plan year. Some plan sponsors use a non-calendar year for important business-related purposes, such as the beginning of a business cycle.

Plan sponsors need certainty with respect to expenses within the plan year, so need to be able to determine tax-related expenses with respect to the benefits that will be incurred and paid during that year. Plan rules regarding deductibles, out-of-pocket maximums and other cost-sharing requirements are generally established based on that plan year, and experience for that year will be calculated in order to determine plan costs for the year. For non-calendar year plans to use an off-year cycle would require extensive changes in plan financial accounting, and may result in plan sponsors being required to move to a calendar year basis to accommodate the excise tax calculations. This would impose an administrative burden that is unnecessary.

Section 4980I(f)(8) provides that the excise tax term "taxable period" means the calendar year or such shorter period as the Secretary may prescribe. In addition, different taxable periods may be designated for employers of varying sizes. Consequently, it appears that Treasury has the discretionary authority to permit plan sponsors to use either a calendar year taxable year or non-calendar year taxable year, based on the plan's operations. The Retiree Drug Subsidy program, operated by the Department of Health & Human Services, provides subsidies to plan sponsors of a retiree drug program that meets certain criteria. This program permits plan sponsors to participate in and value their drug program on a plan year basis, and conducts reconciliations 15 months after the end of the plan year. The process works well for all parties, as plan sponsors have not had to adjust their administration to seek the subsidy, and HHS and service providers can perform reconciliation on a rolling basis. If Treasury and IRS do not permit flexibility with respect to the taxable period, at the very least, a transition year should be created to allow the tax to be calculated for the first plan year beginning after December 31, 2017.

Similarly, a process should be adopted for plan sponsors to use one threshold for their entire non-calendar year. For example, several plan benefit rules, such as the maximum out-of-pocket rule for non-grandfathered plans, permit calculation of an ACA requirement based on the sponsor's existing plan year. The threshold for excise tax purposes should be able to remain consistent during the term of the sponsor's plan year.

In prior comments, we have argued that plan sponsors should have the flexibility to determine the cost of coverage at the beginning of the plan year using either the actuarial basis or past cost method, but also to be able to determine the actual cost of coverage after the end of the plan year, if that proved lower than the cost determined up front. If plan sponsors are permitted to determine costs at the end of the plan year, significant time should be provided for both the claims run-out period and the tax calculation and notice process. We again suggest that the Retiree Drug Subsidy reconciliation period of 15 months may provide a good example of a methodology for collection if actual costs during the taxable period may be determined.

C. Exclusion of the Cost of Applicable Coverage of Amounts Attributable to the Excise Tax

Notice 2015-52: The Notice proposes that the tax itself will be excluded from the cost of coverage. The Notice further provides that, in the event the tax is payable by a person other than the employer (e.g., an insurer), it is expected that the coverage provider will pass through the cost of the tax, including an amount to offset the income tax that will be due because the tax reimbursement is taxable income. The Notice proposes that both the tax and any income tax reimbursement will be excluded from the cost of the tax, if such amounts are separately stated. The Notice asks for comments on this approach, as well as timing issues (i.e., because the coverage provider generally will not know the amount of the tax and will not be able to separately bill for it until after the end of the taxable period).

NCCMP Comments:

NCCMP supports developing an appropriate means to exclude the excise tax and related amounts from the cost of coverage, and believes that this is required by the statute. Section 4980I(d)(2)(A) provides that "*any* portion of the cost of such coverage *which is attributable* to the tax imposed by this section shall not be taken into account." (emphasis added) Thus, the statute requires that not only the tax itself be excluded from cost, but also all amounts attributable to the tax. Amounts "attributable to" the tax (in addition to the tax itself), include the effects of non-deductibility of the tax, the income tax attributable to any reimbursement of the tax, as well as state and local tax effects. Final regulations should contain rules that ensure that all of these amounts are excluded in determining cost.

Creating an appropriate mechanism for excluding amounts attributable to the excise tax from cost will by necessity involve some administrative complexity. Such complexity can be reduced by having an appropriate definition of coverage provider that minimizes the number of coverage providers involved and the situations in which a third party is liable for the tax. Thus, as recommended above, at least in the case of self-funded multiemployer plans, the coverage provider should be the person with ultimate responsibility for plan benefits, i.e., the plan sponsor. This would leave the more difficult pass through issues to be addressed only in the context of fully-insured plans.

Whether the proposed approach of requiring separate billing of any excise and related amounts will be workable depends, at least in part, on how insurers may or are required to treat any tax and related amounts for rating purposes. Any mechanism for excluding amounts attributable to

the tax must take into account state insurance laws and insurer practices. Plans should not be forced to include the tax in the cost of coverage if insurers fail to separately state amounts attributable to the tax.

There are some potential issues under ERISA with respect to whether multiemployer plan trustees may use plan assets to pay any separately stated excise tax (and related amounts) that are passed through by an insurer or other third party that may be liable for the tax. The potential issue arises because the tax liability in such cases would not be that of the multiemployer plan or plan sponsor. As a practical matter, however, multiemployer plans with fully-insured plans already pay similar amounts today, because taxes and fees are routinely included in the cost of full-insured coverage. Thus, for example, insurers' rates will take into account any reinsurance fee, health providers fee (ACA § 9010), or other taxes and fees, including state and local taxes. Although not separately stated in the premium, the premium will include such costs. Thus, just as plan assets may be used to pay premiums, which include such taxes and fees, multiemployer plan assets should be able to be used to pay any excise tax and related effects that are passed through by the insurer (or other third party). NCCMP has had preliminary discusses with the DOL with a view toward resolving any potential plan asset issues, and recommends that Treasury and IRS also confer with DOL on these issues as they develop further guidance.

D. Income Tax Reimbursement Formula

Notice 2015-52: The Notice outlines possible ways of determining an income tax reimbursement amount, should IRS/Treasury conclude that such amount is properly included in the cost of coverage. The Notice describes a formula that could be used, which is based in part on the marginal tax rate of the coverage provider. The Notices include two alternatives for determining the marginal rate, the coverage provider's actual marginal tax rate and a standard marginal tax rate.

NCCMP Comments:

As discussed just above, NCCMP believes that the statute requires that all amounts attributable to the excise tax be excluded from the cost of coverage for purposes of determining the tax. For purposes of determining the income tax effect, it would be helpful to have a standard rate that could be used as a safe harbor; however, the ability to use actual rates should also be permitted. Further, as discussed above, the cost of coverage should exclude all amounts attributable to the tax, including an adjustment to account for the non-deductibility of the tax and state and local tax effects.

The exclusion of amounts attributable to the tax is required by the statute and is also consistent with sound policy. Exclusion of such amounts is needed to prevent ballooning of the tax due to paying tax on tax.

E. Allocation of Contributions to HSAs, Archer MSAs, FSAs, and HRAs

Notice 2015-52: The Notice states that IRS/Treasury are considering a rule providing that, in the case of account-based plans, including HSAs, FSAs and HRAs that are applicable coverage,

contributions would be allocated on a pro-rata basis over the period to which the contribution relates (generally, the plan year), regardless of the timing of the contributions during the period. As an example, the Notice says that, under this approach, if an employer contributes to an HSA that is applicable coverage for a plan year, the contribution would be allocated ratably to each calendar month in the plan year, regardless of when the contribution is actually made.

NCCMP Comments:

The proposal responds to one concern raised in the NCCMP comments on Notice 2015-16, i.e., that the excise tax is determined on a monthly basis, whereas contributions to account-based plans, such as HRAs, are often intended for use for an annual (and sometimes longer) period. The proposed approach will help address this concern, at least where contributions are primarily intended for annual use. However, as noted in our prior comments, HRAs are designed in many different ways for many different purposes, thus the proposed rule is not adequate to address all situations. NCCMP suggests that this be an optional approach. Further, future guidance needs to address the other issues raised in our prior comments regarding HRAs, which are summarized below:

With respect to determining the cost of coverage under an HRA, NCCMP recommends the following:

- Plan sponsors should have flexibility with respect to the method used to determine the cost of coverage under an HRA. Such flexibility is important due to the various different ways in which HRAs may be used. Depending on how an HRA is structured, some methods, for example, such as looking at amounts newly made available, may tend to overstate the actual value of the coverage in a particular year.

    - Permitted options to determine cost should include: (1) looking at amounts newly made available each year, disregarding any carry-over amounts and amounts made newly available before 2018; (2) adding claims and administrative expenses and dividing by number of covered participants; and (3) determining costs on an actuarial basis method.

    - The cost of coverage should not include an HRA that can only be used to fund the employee contribution toward coverage (including any contribution for retiree coverage). Failure to exclude such amounts would result in double counting.

      If the HRA may be used toward the cost of coverage and other benefits, plan sponsors should be able to use any reasonable method, e.g., actuarial estimates, to allocate the cost of the HRA between the different benefits.

    - HRAs that may be used only at retirement should not be factored into the cost of active coverage even though amounts are contributed during active employment.

- The cost of coverage should not include an HRA that reimburses only for excepted benefits that are not subject to the excise tax.

- If the HRA may be used toward the cost of excepted benefits and benefits that are applicable coverage, plan sponsors should be able to use any reasonable method, e.g., actuarial estimates, to allocate the cost of the HRA between the different benefits.

With respect to valuation of HSAs, we also wish to reiterate the points raised in our prior comments that statutory language requires that an applicable coverage must be a group health plan. As detailed in our prior comments, in most cases HSAs are not group health plans. Thus, future guidance should clearly restrict the application of the excise tax only to HSAs that are group health plans. Further, to the extent an HSA is subject to the excise tax, NCCMP believes the statutory language supports the exclusion of salary reduction HSA contributions from the excise tax base.

SECTION VI: Age and Gender Adjustment to the Dollar Limit

A. Determination of Age and Gender Distribution

Notice 2015-52: The statute provides for increasing the dollar thresholds if the age and gender characteristics of the employer exceed a national average. The Notice proposes that the national average will be determined by using the Current Population Survey as summarized in Table A-8a, Employed Persons and Employment-Population Ratios by Age and Sex, Seasonally Adjusted, published annually by the DOL Bureau of Labor Statistics (BLS). The Notice proposes that an "employer" will use the first day of the plan year as a snapshot date for determining the composition of its workforce.

NCCMP Comments:

1. Determining the national workforce.

While the NCCMP agrees that the Current Population Survey (CPS) should be the data source used, we recommend that the "national workforce" be defined as the "civilian labor force" and that Table A-8a (and the data used to construct it) not be used.

Section 4980I does not define "national workforce" and there does not appear to be a definition of that term elsewhere in federal law. Since Congress provided no specific definition and placed no specific limitations on its meaning, we suggest that Treasury and IRS adopt a definition that is consistent with a broad, common sense understanding of this term, as well as one that is based on data that the federal government already collects. Defining the "national workforce" as being made up only of employed persons, as Treasury and IRS would do if they used the same data from the CPS as is used to construct Table A-8a, is inconsistent with our recommended approach and would narrow inappropriately the scope of American workers used to determine the age and gender distribution.

Treasury and IRS should, instead, define the "national workforce" to be the same as the "civilian labor force," a term that is used by BLS. The "civilian labor force" is made up of all persons in the civilian non-institutional population who are classified as either "employed" or "unemployed." Annual average statistics for the civilian labor force can be found in the CPS

data set out in Table 3, "Employment status of the civilian non-institutional population by age, sex, and race."

It is appropriate to use data for the civilian labor force, including employed and unemployed individuals, to determine the age and gender distribution of the national workforce. Unemployed individuals, like all employed individuals, are part of the pool of individuals who may be enrolled as a primary insured individual in employment-based coverage. In the case of unemployed individuals, they may be eligible to enroll in coverage if they have a right to continuation coverage under federal or state law. Further, multiemployer plans often provide uninterrupted coverage to some workers during certain periods of unemployment, through the use of hours banks and other provisions. Given these circumstances, it would be inappropriate to exclude unemployed workers from the data set used to determine the age and gender characteristics of the national workforce.

There are other concerns with Table A-8a. The Notice states that Table A-8a provides data by five-year age bands up to age 75 and over. However, Table A-8a breaks the data into age bands of different lengths, ranging from two years to ten years. In addition, Table A-8a combines all individuals age 55 and older into one age band (not age 75 and older). The NCCMP would prefer age bands of one year so that, for example, a plan with an average age of 45 would get a higher adjustment than a plan with an average age of 44. In addition, whatever table is used needs to extend past age 65 and should not combine all individuals age 55 and older. This is particularly important for plans with a high number of active participants who are 65 or older, because the plan will continue to pay primary to Medicare due to their employment status. Combining individuals who are age 75 and older would be acceptable (as is the case with the Table 3 noted above).

2. Snapshot for determining the population.

For a multiemployer plan, the relevant population will be the plan's participants, not the age and gender characteristics of a particular employer's workforce. The regulations should clarify that the age and gender adjustments would apply to multiemployer plans based on the characteristics of the participants in the plan. The plan will not have any information regarding the age and gender characteristics of the employees of its contributing employers who are not participants in the plan. The NCCMP also recommends that plan sponsors be given flexibility to determine the composition of the plan's participants on any specific date of the plan year. Requiring plan sponsors to use the first day of the plan year might not accurately reflect the composition of a population subject to seasonal variations.

B. Development of Age and Gender Adjustment Tables

Notice 2015-52: The Notice outlines a seven-step approach for the development of tables and the calculation of the age and gender adjustments. At the outset, this section of the Notice states: "All adjustments and calculations would be determined separately for self-only coverage and for other than self-only coverage."

NCCMP Comments:

The seven steps that are set out in the Notice generally reflect a sound approach. The NCCMP offers the following specific comments:

- Any reference to the "employer's premium" would need to refer to the plan's premium in the case of a multiemployer plan, while each reference to the employer's "employees" would need to refer to the plan's participants.

- As discussed at length in the comments submitted by the NCCMP in response to Notice 2015-16, the statute provides: "Any coverage under a multiemployer plan (as defined in [Code] section 414(f)) shall be treated as coverage other than self-only coverage." Consistent with this directive, multiemployer plans are not required to calculate a separate cost for self-only coverage. As a result, the regulations should make it clear that multiemployer plans would only use the adjustment applicable to other than self-only coverage.

- The Notice asks for comments on using actual FEHBP claims data or national claims data reflecting plans with a design similar to the FEHBP standard option for Step 1. The statute refers to the premium cost if "priced for the age and gender characteristics of the national workforce." That would appear to require the use of national claims data, unless the age and gender characteristics of the federal workforce are comparable to the national workforce.

- Step 2 suggests the use of five-year age bands. As discussed above, the NCCMP prefers one-year age bands, but age bands of no more than five years would be acceptable, provided they continue to age 75 (with individuals age 75 and older grouped together). The data should exclude any participants for whom Medicare pays primary. The NCCMP also suggests that Treasury and IRS may want to use graduation methods to smooth out any anomalies that may occur with the data.

- The NCCMP requests that Treasury and IRS make the process of calculating the adjustments as simple as possible for plan sponsors. For example, Treasury and IRS could create a spreadsheet that would only require plan sponsors to input data (i.e., counts by age or by age and sex).

SECTION VII: NOTICE AND PAYMENT

A. Notice of Calculation of Applicable Share of Excess Benefit

Notice 2015-52: The Notice requests comments on the requirement that "employers" are to calculate the excess benefit and notify the IRS/Treasury and each coverage provider of the amount.

NCCMP Comments:

The Notice refers to the notification requirement on the "employer". However, with respect to coverage under a multiemployer plan, Code § 4980I(c)(4) imposes this requirement on the "plan sponsor". Under § 4980I(f)(7), the "plan sponsor" is defined for this purpose the same way it is defined under ERISA § 3(16)(B). Under that definition, the plan sponsor is the joint board of trustees of the plan. The statutory rule reflects the fact that, in the multiemployer plan context, the plan sponsor, rather than contributing employers, has information regarding plan coverage. Further guidance should reflect the notification requirement as it applies in the case of multiemployer plan coverage.

In some situations, a multiemployer plan participant may have coverage under a plan with a different plan sponsor. This could occur in a variety of circumstances. For example, pursuant to Notice 2013-54, an HRA may be integrated with a non-HRA plan of a different plan sponsor. As another example, a multiemployer plan participant could have coverage under a plan sponsored by an employer of the individual. In such situations, the multiemployer plan sponsor would only have a notification requirement with respect to coverage it sponsors and not with respect to coverage of a different plan sponsor. While this seems clear, clarification of this point would be helpful.

B. Payment of the § 4980I Excise Tax

Notice 2015-52: The Notice proposes that coverage providers will remit the tax using Form 720, Quarterly Federal Excise Tax Return, except that it will be filed only once per taxable period, at a time to be specified.

NCCMP Comments:

NCCMP supports remitting the tax only once per taxable period, rather than more frequently.

Conclusion

NCCMP greatly appreciates the opportunity to comment in advance of rule-making on issues relating to multiemployer plans and the excise tax under § 4980I. Because plan participants will ultimately bear the burden of this tax, it is particularly important that it be implemented so as to reduce needless burdens. We look forward to commenting on additional issues as the guidance process continues. We are more than happy to discuss any questions you may have regarding these comments and related issues.

Respectfully submitted,

Randy G. DeFrehn
Executive Director